Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GUNNISON VALLEY HOSPITAL
711 N TAYLOR STREET
GUNNISON CO 81230

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-9147-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am submitting to you a medical fee dispute resolution for our patient, [injured employee]. We submitted the attached bill to Gallagher Bassett and they have processed and denied this bill as procedure code was invalid for service date. I have attached their authorization for the procedure code that we have billed for during the dates they authorized of 10-June-2008 thru 08-Sep-2008. This service was clearly done during that time frame. We are asking that they send this thru to be processed by their bill review company and make an appropriate payment from either the Texas or Colorado Fee Schedule. I have attached all documentation that you may need to process this dispute."

Amount in Dispute: $6,284.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has reviewed this bill for medical services again. Per bill audit, the EOB is correct and the carrier will not issue any additional reimbursement."

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2008	Outpatient Hospital Service CPT Code 49650 (APC Amount - $2,900.10 x 200% = $5,800.20 - $29.50 (carrier payment))	$6,284.93	$5,770.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.403 sets out the procedures for reimbursement of outpatient hospital charges.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 17, 2009
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 45, W1 & 18 (181) – This line was included in the reconsideration of this previously reviewed bill.
   - 18 (181) – Payment adjusted because this procedure code was invalid on the date of service.
   - BL – This bill is a reconsideration of a previously review bill.
   - 16 – Claim/service lacks information which is needed for adjudication.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the respondent reimburse the requestor in accordance with 28 Texas Administrative Code §134.403?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided hospital outpatient services in the state of Colorado on June 18, 2008 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was paid $29.50 after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of under-payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable division rules.
2. 28 Texas Administrative Code §134.403(f)(1)(A) states that the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied: (1) the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by (A) 200 percent.
3. Review of the submitted documentation finds that the requestor is due reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,770.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,770.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 2, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.